SKILLED NURSING FACILITY SERVICES PAYMENT SYSTEM

*payment***basics**

Beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in skilled nursing facilities (SNFs). Skilled nursing facilities can be hospital-based units or freestanding; in 2003, 83 percent of stays were in freestanding facilities. With approval from CMS, certain Medicare-certified hospitals (typically small, rural hospitals and critical access hospitals) may also provide skilled nursing services in the hospital beds used to provide acute care services. These are called swing bed hospitals. SNFs are the most commonly used post-acute care setting. Spending on SNFs was 6 percent of total Medicare spending in 2003. Medicare paid $14.3 billion for about 2.4 million SNF admissions in 2003.

Medicare's prospective payment system (PPS) for SNF services started on July 1, 1998.[1] Under the PPS, SNFs are paid a predetermined rate for each day of care. Prior to that, SNFs were paid on the basis of their costs, subject to limits on their per diem routine costs (room, board, and routine nursing care); no limits were applied for ancillary services (such as drugs and therapy).

The SNF product

Patients are assigned to one of 53 resource utilization groups (RUG-53).[2] The RUG-53 groups patients with similar characteristics and service needs that are expected to require similar resources. Patients' characteristics and service needs are determined by periodic assessments using the SNF patient assessment instrument, known as the Minimum Data Set. As shown in Figure 1, assignment of a beneficiary to a RUG–53 group is based on the number of minutes of therapy (physical, occupational, or speech) that the patient has used or is expected to use; the need for certain services (e.g., respiratory therapy or specialized feeding); the presence of certain conditions (e.g., pneumonia or dehydration); an index based on the patient's ability to perform independently four activities of daily living (eating, toileting, bed mobility, and transferring); and in some cases, signs of depression. Each RUG-53 has associated weights used to adjust the base payments to reflect differences in patient's expected resource use. In 2003, the most commonly billed RUGs were the "very high" and "high" rehabilitation groups.

Setting the payment rates

The PPS rates are expected to cover all operating and capital costs that efficient facilities would be expected to incur in furnishing most SNF services, with certain high-cost, low-probability ancillary services paid separately.[3] The initial payment rates in 1998 were set to reflect the projected amount that SNFs received in 1995, updated for inflation.[4] The nursing and therapy base payment rates are computed separately for urban and rural areas, and the rates are adjusted to account for differences in input prices among SNF markets. The daily rate is the sum of three components:

- a nursing component, reflecting the intensity of nursing care patients are expected to require.
- a therapy component, reflecting the amount of therapy services provided or expected to be provided; and
- a routine service component reflecting the costs of room and board, linens, and administrative services.

The nursing component is case-mix adjusted for all RUGs. The therapy component is case-mix adjusted for rehabilitation RUGs and is a constant

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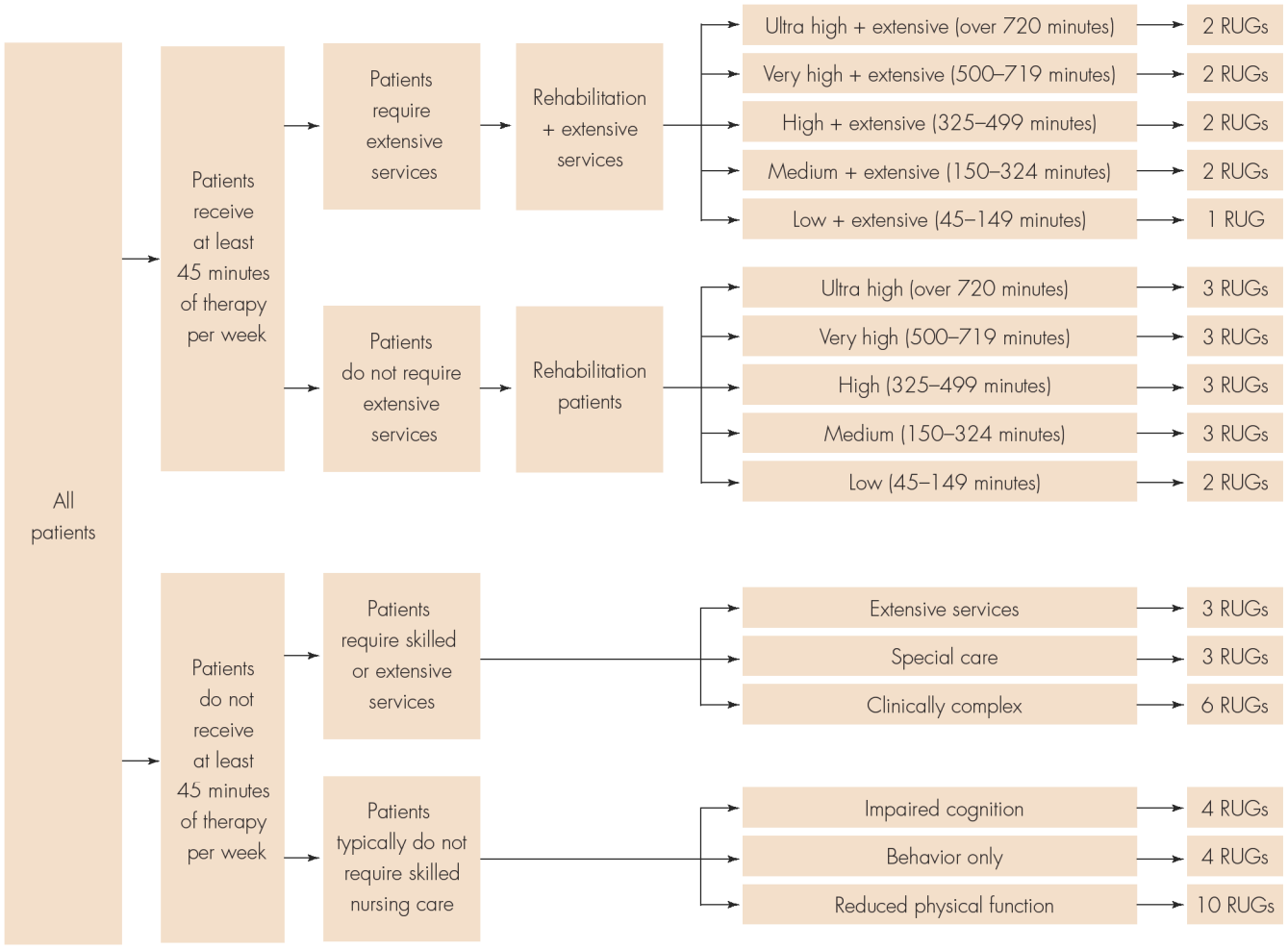
Figure 1 RUG–53 classification system



Note: RUG–53 (resource utilization group, 53-group model). Differences between RUGs are based on activity of daily living score, service use, and the presence of certain medical conditions. The extensive services category includes patients who have received intravenous medications or tracheostomy care or required a ventilator/respirator or suctioning in the past 14 days or have received intravenous feeding in the past seven days. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory therapy seven days per week, or are aphasic or tube-fed. The clinically complex category includes patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy.

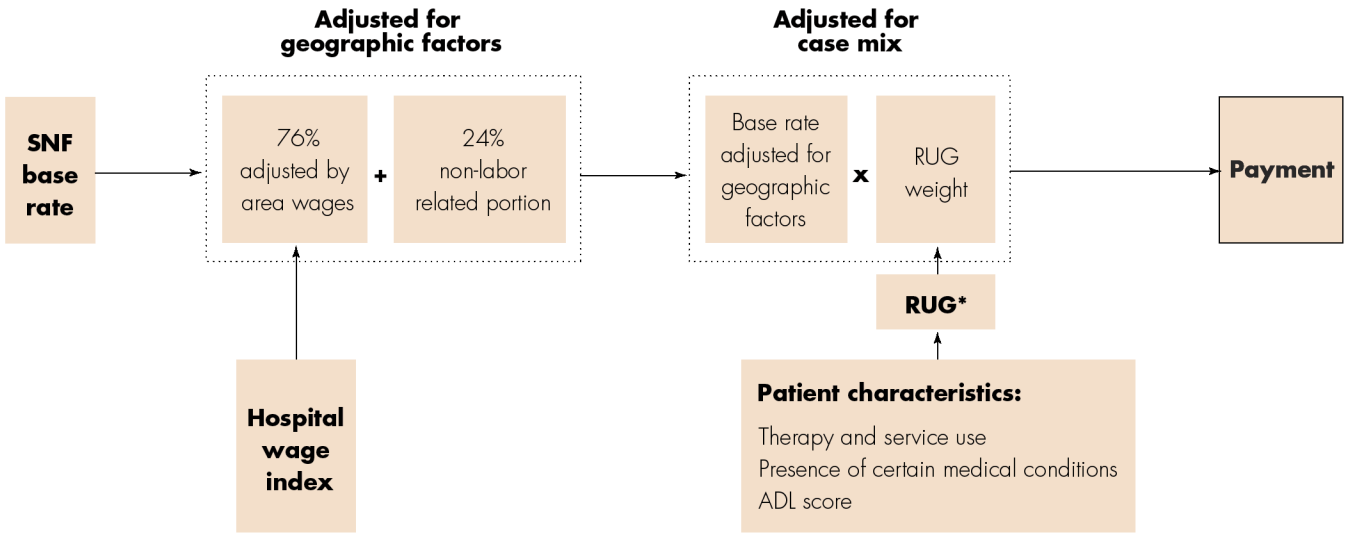
Source: Figure adapted from Government Accountability Office. 2002. *Skilled nursing facilities: Providers have responded to Medicare payments systems by changing practices*, no. GAO–02–841. Washington, DC: GAO.

amount for nonrehabilitation RUGs. The routine service component is a constant amount for all RUGs.

In addition to adjustment for case mix, the base rate is adjusted for geographic differences in labor costs (Figure 2). The labor-related portion of the total daily rate—76 percent for fiscal year 2006—is multiplied by the hospital wage index in the SNF's location and the result is added to the nonlabor portion. Rates are updated annually based on the projected increase in the SNF market basket index, a measure of the national average price level for the goods and services SNFs purchase to provide care.

Because of some perceived problems with the SNF payment rates for clinically complex patients with high nontherapy ancillary costs (such as IV therapy and prescription drugs), the Congress

Figure 2 Skilled nursing facility services prospective payment system



Note: SNF (skilled nursing facility), RUG (resource utilization group), ADL (activity of daily living).
*See Figure 1 for more detail on case-mix adjustment.

temporarily increased the rates in several ways since the implementation of the PPS. Some temporary increases expired on October 1, 2002.

The Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) temporarily increased rates for 14 rehabilitation groups by 6.7 percent, and those for 12 complex care groups by 20 percent. These increases were intended to give CMS time to refine the RUG-III classification system and expire on January 1, 2006 when CMS adopts the RUG-53 system.[5] The RUG–53 system retains the former 44 group RUG structure and adds 9 new extensive services plus rehabilitation payment groups. These new groups became the highest payment categories. CMS also increased the weights of the new and existing payment groups. In our comment letter on the proposed rule, we noted that this refinement does not help to achieve CMS's stated goal of more appropriate payment because the payment system does not have a mechanism for targeting payment for nontherapy ancillary services.[6] ■

1 On July 1, 2002, Medicare began paying swing bed hospitals that are not critical access hospitals according to the SNF prospective payment system. Critical access hospitals continue to be paid for their swing beds based on their costs of providing care.

2 As of January 1, 2006, the RUG-53 classification system goes into effect, replacing the 44 group RUG-III payment system. Until January 1, 2006, CMS will use the RUG-III classification system.

3 The SNF per diem payment rates do not cover the costs of physician services or services of certain other practitioners (such as qualified psychologists). Medicare Part B still covers these services. In addition, to limit SNFs' liability for services typically outside the scope of SNF care, the Congress excluded payments for certain high-cost, low-probability ancillary services from the SNF per diem rates. Thus, Medicare pays separately when SNF patients receive emergency room care, outpatient hospital scans, imaging and surgeries, and certain high-cost chemotherapy agents and prosthetic devices. But the per diem rates do cover the costs of physical, occupational, and speech therapies, even if a physician supervises.

4 By law, this projection excluded costs of SNFs that were exempt from Medicare's routine cost limits and costs related to payments for exceptions to the routine cost limits. In 1995, it included only 50 percent of the difference between the average costs of hospital-based and freestanding facilities.

5 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 increased the per diem payment for a SNF resident with AIDS by 128 percent for services furnished on or after October 1, 2004. This payment increase is still in effect and does not expire when the RUG–53 system goes into effect.

6 For additional information on our comments to the proposed rule, see http://www.medpac.gov/publications/other_reports/070805_MedPAC_SNF_comment.pdf.